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ABSTRACT

Multiple personality disorder (MPD) is now recognized as a valid diagnostic category. Occurrence may be higher than previously suspected. While physiological testing of MPD has shown significant differences between the various personalities of individuals in terms of galvanic skin response, electroencephalogram recordings, electrodermal response movements, and visually evoked potential recordings, it offers little as an indicator of MPD, with the Rorschach and the Minnesota Multiphasic Personality Inventory (MMPI) having the greatest potential for predicting MPD in clients. Although a distinct MMPI profile representative of MPD does not exist, the Rorschach appears to be more discriminating than the MMPI and may eventually prove diagnostically useful. Further research in this area is needed. Abuse, incest, and other severe trauma during childhood are consistently listed as etiological factors of MPD. The recent increase in cases of reported child abuse presents the opportunity to identify MPD patients early. This early detection may eliminate years of intensive therapy or trauma. The most practical means of diagnosis is through interviews. Practitioners who interview abuse victims should consider MPD as a possible diagnosis. Helpful checklists exist, most of which cite amnesia, auditory hallucinations, unusual fluctuations, and imaginary playmates as possible indicators of MPD in children. Other indicators of MPD in adults and methods of further inquiry can help the clinician recognize and make decisions regarding treatment of MPD. A three-page reference list is provided. (Author/NB)

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INDICATORS OF MULTIPLE PERSONALITY DISORDER
FOR THE CLINICIAN

Doctoral Research Paper
for the Degree of Doctor of Psychology

ROSEMEAD SCHOOL OF PSYCHOLOGY

BIOLA UNIVERSITY

THOMAS W. DALTON

1985

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FOR THE CLINICIAN

BY

THOMAS W. DALTON

A doctoral research paper submitted to
Rosemead School of Psychology
in partial fulfillment of the requirements
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La Mirada, California

1985

INDICATORS OF MULTIPLE PERSONALITY DISORDER
FOR THE CLINICIAN

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ABSTRACT

INDICATORS OF MULTIPLE PERSONALITY DISORDER

FOR THE CLINICIAN

BY

THOMAS W. DALTON

Multiple personality disorder (MPD) is now recognized as a valid diagnostic category. Occurrence may be higher than previously suspected. Physiological testing shows significant differences between alternate personalities within individuals but offers little as an indicator of MPD not previously suspected. Psychological testing using the MMPI and the Rorschach offers more hope as indicators of MPD. Detection of MPD in childhood is now more likely given helpful checklists characterizing MPD patients. Other indicators of MPD in adults and methods of further inquiry can help the clinician recognize and make decisions regarding treatment of MPD.

Indicators of Multiple Personality Disorder
for the Clinician

Recently a gradual shift has taken place in the discussion of Multiple Personality Disorder (MPD). Instead of debating whether it does or does not exist, there has been a serious effort to understand this mysterious and confusing psychological phenomenon. Three journals printed special issues dedicated solely to MPD in 1984 (The International Journal of Clinical and Experimental Hypnosis, 32, No. 2; Psychiatric Annals, 14, No. 1; The Psychiatric Clinics of North America, 7, No. 1). In these journals and related articles one will find MPD discussed from various perspectives. Discussions include etiology (Boor, 1982b; Herzog, 1984; Stern, 1984), diagnostic considerations (Coons, 1984; Herzog, 1984; Solomon & Solomon, 1982), theoretical discussions (Brenner & Joscelyne, 1983; Buck, 1983), and treatment (Braun, 1984b; Kluft, 1984b; Wilbur, 1984). As comprehensive as the literature seems to be, many clinicians may find the information difficult to understand and of little clinical use.

If the low incidence of MPD reported in the past is due to misdiagnosis rather than infrequent occurrence (Greaves, 1980), then it becomes important for the psychotherapist to be better able to recognize the symptoms of MPD. Kluft (1984a) reports that despite subtle but recognizable "hints" many MPD patients go undetected and untreated because of

skepticism towards MPD and unfamiliarity with MPD symptomatology. Coons (1984) concurs with this view, describing several reasons for misdiagnosis and estimating a "conservative" incidence of MPD, 1 per 100,000 people.

A criticism levied at those reporting high incidence of MPD is the concomitant high number of false positives, persons wrongly diagnosed as MPD. The rebuttal is that for too many years the diagnosis has been missed altogether and that even with improving diagnostic capabilities there are too many false negatives being reported, cases of MPD that are overlooked or misdiagnosed. This paper attempts to bridge this apparent gap between those familiar with MPD and those unlikely to recognize subtle or obvious symptoms of MPD.

To prevent over-diagnosis, the limitations of physiological detection and psychological testing will be outlined. Innovative approaches with diagnostic potential will be explored, such as methods for identifying MPD in childhood. A summary of useful checklists and questions to be used in the interview will also be included.

Physiological Detection

Physiological studies of MPD abound. In Putnam's (1984) historical review he presents investigations of galvanic skin response in persons with MPD dating back to 1908. More recently, studies have used electroencephalogram

recordings (Cocores, Bender, & McBride, 1984), electrodermal response movements (Brende, 1984), and visually evoked potential recordings (Braun, 1983a). As with other approaches to the study of MPD, physiological studies have proven to be primarily of use as descriptive tools rather than serving to confirm a diagnosis of MPD. This is true for most psychiatric diagnoses. Putnam (1984) states:

At the present time there is not a single physiologic measure or combination of measures that can reliably establish the existence of any psychiatric diagnostic category. This is a general problem that psychiatry must face and not specific to multiple personality disorder. The question of the existence of multiple personality disorder is at present best left to the same clinical scrutiny applied to other psychiatric syndromes. (p. 37)

A similar conclusion is stated by Coons (1984).

Most physiological studies have measured differences between the various personalities of individuals. Ludwig, Brandsma, Wilbur, Bendfeldt, and Jameson (1972) did extensive physiological testing of Jonah, a male multiple personality. They found significant differences between the four personalities on galvanic skin response, electroencephalogram, and visually evoked potentials. Cortical maps produced from visually evoked potential measures show differences in electrical activity and complexity for each of the personalities in two separate individuals (Braun, 1983a). Differences between personalities of an MPD patient were also noted by Brende (1984) using electrodermal responses.

Coons, Milstein, and Marley (1982) proceeded to show that the different EEG readings obtained from persons with MPD could not be simulated by control persons. Braun (1983a) makes similar claims, citing studies by Putnam and recording significant differences in evoked potential recordings. Cocores et al. (1984) dispute these claims. They state that EEG changes they observed in a multiple personality patient could be ascribed to "normal changes in transitions from various states of alertness" (p. 436). The problem is seen as more complex. The EEG may be affected by seizures, somatic conditions, and nerve disorders. These could be directly related to the occurrence of MPD or may be indicative of an unrelated disorder. Future studies in this area will need to discern whether physiological differences can be "faked" by controls or actors or whether alternate personalities of MPD patients have unique physiological characteristics.

There are other physiological indicators of MPD more difficult to operationally define and study. Ludwig et al. (1972) reported a much reduced or absent two-point discrimination ability and pain sensitivity in one of the personalities of their patient. Severe headaches sometimes accompanied by blackouts are common in MPD cases (Braun, 1983b; Greaves, 1980). Rapid onset of rashes and allergies and subsequent rapid relief of these symptoms were noted in MPD patients by Braun (1983b). Putnam (1984) reported a

high incidence of changes in handedness in patients. None of the above serve as indicators by themselves but they are useful in substantiating suspected cases of MPD.

This evidence is not meant to discourage further physiological study of MPD. Such information as that cited above is helpful in understanding the nature of this disorder. At present, the detection of physiological responses unique to MPD is unlikely if tests are administered one time only. If MPD is suspected physiological tests can be repeated, increasing the likelihood of observing the dramatic changes indicative of multiple personalities.

Typically, a patient would only be tested one time. If more than one personality appeared during a single testing it would be a matter of chance alone. One might suspect that the odds would be against this happening since alternate personalities frequently appear in order to deal with stressful situations. If testing were perceived as threatening to the MPD patient, the alternate personality would be likely to remain present throughout the testing. If testing were not perceived as threatening, an alternate personality would have no reason to appear.

The clinician can still be alert to physiological indicators. Over the course of time changes in handedness might be observed. The patient may have scars, injuries, and mutilations but no memory for their origin. Attention

should be given to rashes and allergies that appear and disappear in an unusual fashion (i.e., sometimes allergic and sometimes not allergic to the same substance or condition). At times symptoms may disappear rapidly (Coons, 1984). None of these conditions, alone, warrant a MPD diagnosis and they could be indicative of any number of alternative diagnoses. Yet they all can serve to point the alert clinician to a MPD diagnosis if, indeed, that is the patient's disorder. What might otherwise be a confusing and conflictual picture, given such a mixture of physiological symptoms, quickly makes sense when properly identified.

The Use of Psychological Testing in Detecting MPD

MMPI

The use of psychological testing to detect the presence of MPD is attractive. Such measures as the MMPI are routinely administered in many settings. Development of a MPD profile that is recognizable and distinguishable from profiles of other disorders might eliminate years of inappropriate therapy due to misdiagnosis. The literature offers some hope for such use of testing but conclusive evidence is currently lacking. There is some question as to the value of such a profile if it did exist since many of the more overt and self-reported symptoms of MPD are available to the practitioner and are adequate for diagnosis.

Freud and Breuer (cited in Solomon & Solomon, 1982) viewed MPD as a hysterical phenomenon which has led some to believe that an elevated Hysteria scale would be found on MPD profiles. Such has not been the case (Solomon & Solomon, 1982). While not explaining how they went about obtaining their subjects, the Solomons report that MPD patients tend to have an elevated Schizophrenia scale. Bliss (1984) concurs with this, adding that an elevated F scale is consistently found. Coons (1984) also found both an elevated F scale and an elevated Schizophrenia scale. He goes a step further by saying that the average MMPI profile he obtained after administering it to 10 of his MPD patients yielded a 8-4-7 profile. Closer inspection of the results reported by both Bliss and Coons shows that several other scales were over the 70 T level or 95th percentile. These include Depression and Paranoia scales in both studies and the Hypochondriasis, Hysteria, and Social Introversion scales as well in Bliss's (1984) study of female MPD patients.

Several problems arise in using the above information. The elevated Schizophrenia and F scales are somewhat helpful in suggesting MPD. But, as one can see, these two scales seldom stand alone, thus clouding the profile quickly. The other elevated scales that may follow are perhaps more confusing than diagnostically helpful. The 8-4-7 profile is indicative of a borderline personality. The relative

similarity of elevations on the other scales could lead to any number of alternative plausible diagnoses.

This points out one of the problem areas encountered in diagnosing MPD in general. Persons suffering from MPD are frequently given diagnoses for other disorders that may coexist with the MPD (Coons, 1984). Bliss (1984) comments, "...it seems likely that this typical MMPI profile will be suggestive but not diagnostic" (p. 199). Coons (1984) makes a similar statement, "Although psychological testing has been helpful in providing relevant data after the diagnosis of multiple personality has been made, it has not proved helpful in making the initial diagnosis, except on rare occasions" (p. 63).

Even the MMPI's "suggestive" value is questionable. Ludwig et al. (1972) did thorough testing on a male subject diagnosed as MPD. They found in administering the MMPI to each of the distinct personalities that each personality yielded a different and valid profile. One of the profiles did indeed show the elevated F and Schizophrenic scales (although the Paranoia scale exceeded even the Schizophrenic scale). The three-point profile was not the 8-4-7 reported by Coons (1984), but rather a 6-8-4, 7 being one of the lower scales. The other three profiles not only failed to display the high Schizophrenia and F scales but in fact had profiles with no scales above 70 T, F being the low scale in the validity configuration. The first profile mentioned was

that of the subject's original personality, which lends some support to the notions of Coons and Bliss. However, there is no guarantee that the personality taking the test will be the original personality. This makes the MMPI an even more questionable tool for diagnosis of MPD.

Rorschach

Another assessment tool showing some promise as an indicator of multiple personality is the Rorschach. Wagner, Allison, and Wagner (1983) outline five "rules" that would aid in diagnosing MPD from the Rorschach. The first is a large number of movement responses in the record. Second, diversity of human movement, both active and passive, is likely. The third indicator of MPD is the presence of themes of pursuit or attack expressed in the movement responses. Fourth, one can expect at least three color responses with the sum of pure color responses and color-form responses exceeding the number of color responses in which form predominates. The fifth rule is that color responses are used to express both negative and positive affect. The Rorschach was administered to a confirmed MPD subject by Wagner et al. (1983). The protocol did indeed follow the five rules as suspected.

These diagnostic indicators need to be replicated in studies using more than one subject. If the rules do prove to be characteristic of MPD, the Rorschach could prove to be a useful tool in diagnosis. It has the advantage of being

more discriminating than the MMPI. At present Wagner et al. (1983) are willing to admit the limitations of using the Rorschach to diagnose MPD while still claiming its value of "alerting the clinician to the possibility that such a condition exists" (p. 148).

Other Tests

Ludwig et al. (1972) did extensive psychological testing on their patient, Jonah. Several intelligence measures were given along with an adjective checklist measuring personality characteristics, a draw-a-person test, memory tasks, and the MMPI. Comparisons were made between the four identified personalities on the basis of the administered tests. While they were able to show significant differences among the four personalities, their work did little to advance testing as a means of early detection of MPD.

There are currently two main uses of testing for MPD. It serves as a crude screening device and it has proven useful as a descriptive tool once MPD has been identified. There is enough evidence in the literature to warrant the suspicion of MPD given certain MMPI profiles. Likewise, if the five Rorschach indicators described by Wagner et al. (1983) are present, it would be wise to follow this testing with a clinical interview, exploring whether MPD is actually present. Since only one administration of most tests is normally given, it is unlikely that differences in profiles

or other measures would come to the attention of the clinician. However, even within the context of one instrument, there is evidence that might be diagnostically valuable. Changes in handedness is an example of a useful indicator that might be observed during the administration of a test. Mood shifts, handwriting that is qualitatively different, and other behavioral changes would be noteworthy.

Once MPD has been diagnosed, further testing can add to the understanding of this still mysterious disorder. MMPI results, while ambiguous as a predictor of MPD, can be helpful in detecting other complications often involved in MPD, such as schizophrenia, depression, and alcoholism. Wagner et al. (1983) discuss the "repression" MPD subjects incorporate when a personality emerges that is unaware of other existing personalities. The idea is derived from test responses mentioning being swallowed up, destroyed, and being kept down. MPD patients' tendency to act out and their low frustration level can be observed when administering the Bender Gestalt and some of the Wechsler scales (Solomon & Solomon, 1982).

The Rorschach and the MMPI are the two measures offering the greatest potential for predicting MPD in clients. It will be important to begin to obtain standards to which suspected cases of MPD can be compared. This can best be done by testing and re-testing diagnosed MPD patients. While reliable diagnostic indicators of MPD would

provide a major breakthrough, the very nature of the disorder makes such a possibility unlikely. Complications of many other presenting symptoms and disorders mask the underlying MPD, if indeed there is a characteristic disorder that is identifiable.

Diagnosis in Childhood

Some evidence suggests that MPD is established by the age of five years (Fagan & McMahon, 1984). Herzog (1984) suggests that MPD may originate even earlier, but recollection is impossible for those suffering from MPD since cognitive functions have not reached a point developmentally to allow for the memory of such an occurrence. He relates that the first report of a "subpersonality" is usually between the ages of four to six. Fagan and McMahon (1984) cite eight years as the latest age of onset, with the exception of some rare cases of adult onset.

Abuse, incest, and other severe trauma during childhood are consistently listed as etiological factors of MPD (Boor, 1982a; Brown, 1983; Saltman & Solomon, 1982; Stern, 1984). While abuse does not necessarily produce MPD, there is a high correlation. The point here is that one group of practitioners who need to make themselves aware of MPD symptomatology would be those dealing with children who are victims of molestation and abuse. Workers who are alert to

these clues might be able to detect youngsters who have begun to use MPD as a means of coping with the trauma in their lives.

Only recently has the investigation of MPD broadened to children (Fagan & McMahon, 1984; Kluft, 1984c). Kluft's (1984c) review of the literature reveals only one reported case of MPD in children. Fagan and McMahon (1984) indicate that others are beginning to report diagnosis of MPD in children more frequently. They present four cases with which they were familiar and Kluft (1984c) presents five cases with which he has had personal contact. One is left with the impression that they suspect a much higher incidence of MPD in children than is being reported.

The encouraging aspect of these reports is the apparent success in treatment of childhood MPD. Not only have the symptoms been relieved but they have been relieved in a fraction of the time it takes to accomplish similar results in adults (four to six months for children compared with an average of 6.8 years for adults). These results provide strong motivation for early recognition and treatment of MPD (Kluft, 1984c).

Kluft (1984c) has listed 29 indicators of MPD in childhood, some from an earlier list by Putnam. Fagan and McMahon (1984) also included indications of MPD in children that could be recognized by teachers and parents. They also included a list of six additional subjective criteria of

MPD. Each of these lists of diagnostic criteria are admittedly tentative. Kluft even refuses to combine his list with Putnam's after using the lists with some MPD cases. He predicts that given a broader range of clients, one will find higher incidences of some of the listed characteristics. Below is a list derived by combining Kluft's list, Putnam's list and observations by Fagan and McMahon. Some characteristics may seem repetitious but were included so as to avoid leaving out important diagnostic considerations. Items common to all three lists are listed first, not necessarily as evidence of their value as predictors as much as a statement of the agreement between authors as to their existence. It is hoped that such a list can be used to detect possible cases of MPD in children without creating a flood of false positives. For instance, imaginary playmates is not a hard sign of MPD in children. Yet, combined with several other diagnostic symptoms, a good case might be made for referring this child to a specialist on MPD.

Indicators of Childhood MPD¹

1) Amnesia. This is probably one of the most frequently cited symptoms of MPD in both adults and children. In children it might better be described as forgetfulness.

¹ Sources of indicators will be noted as follows: K-- Kluft, (1978) as cited in Kluft (1984c); P-- Putnam (1981) as cited in Kluft (1984a); F-- Fagan and McMahon (1984).

They may forget names of classmates, teachers, basic routines, and events from the previous day or even earlier within the same day. (K,P,F)

2) Auditory hallucinations. There is a qualitative difference in the voices heard by those with MPD. Rather than hearing an external voice, they often report that it is as if the voice is within their own head. (K,P,F)

3) Unusual fluctuations. Unusual fluctuations in such things as mood, personality, physical skills and abilities, and age-appropriateness may be present. One might notice variations in penmanship, artistic ability, and athletic ability. There might even be a switch in handedness. (K,P,F)

4) Imaginary playmates. Reports have indicated that those with MPD had distinct imaginary playmates who gradually evolved into indistinguishable parts of themselves. (K,P,F)

5) Lying. Accusations may come from peers, teachers, and parents who have viewed actual wrong-doings while the child will deny participation in or knowledge of such an occurrence. (K,P,F)

6) Trance-like behaviors. They appear to be in a daze or in another world. This is characteristic of periods of transition between personalities in which they are still trying to figure out who they are and what has happened. (K, F)

7) Victims of abuse. The abuse may be physical, sexual

and/or psychological. Other traumatic events could also be associated with MPD. Kluft (1984c) points out that it is not the abuse alone that leads to MPD but that MPD "occurs when the traumatized vulnerable individual is not provided adequate buffers against being further overwhelmed, not given nurturing and healing experiences by significant others before the process becomes relatively fixed" (p. 130). The MPD abuse victim usually has no memory for the abuse. (P,F)

8) History of MPD. Other family members may have MPD or have a history of other dissociativeness. (K)

9) Depression. The child might appear lonely, have poor peer relations, and suffer teasing and ridicule because of peculiar behaviors. (K,F)

10) Passive influence experiences. Events and behaviors happen to them. They do not recognize an active role in these things. (K,F)

11) Adult symptoms of MPD. Frequently children will exhibit symptoms similar to those manifest in adult MPD patients (see later section in this paper). Children may attempt to hide these symptoms because adults have punished them for such behaviors. Sometimes the symptoms exist but are not fully developed. (K)

12) Inconsistent school behavior. Skill levels may vary greatly from one day to the next. Some days they are able to accomplish tasks seemingly beyond their abilities and the

next day they are unable to do even simple tasks. (K,F)

13) Previous therapy. Based on presenting symptoms, alternative diagnoses may have been made. Prior treatment of various symptoms is common. They are often very resistant to therapy. (K,F)

14) Danger to themselves or others. This may be manifest in self-mutilation, reckless and careless behavior, assaults towards others, or suicidal gestures. (P,F)

15) Hysterical symptoms. These may include sleep-walking, sudden blindness, seizure-like reactions, paralysis, and loss of sensation. (P,F)

16) Physical complaints. Onset may seem rapid as might be the relief of such symptoms. Some may be related to actual abuse or injury. (P,F)

17) Discipline relatively ineffective. MPD children frequently find themselves being disciplined for "misbehavior", however, discipline efforts tend to be ineffectual. (F)

18) Reference to self in third person. They may use more than one name when talking about themselves. Peers may know them by names foreign to teachers or parents. This creates suspicion, especially when the child expresses unfamiliarity with the other name when using the new name. (P,F)

19) Confusing to others. Frequently the child's behavior is erratic with unclear motives. They become perplexing even to teachers and psychologists. (F)

20) Inappropriate sexuality. They may involve themselves sexually with older persons. .Promiscuity is evident. Mature sexual behaviors occur early, before one would expect. (F)

The reader is reminded that the above list is to be used with caution. Some of the items may prove to be better indicators than others. Others are not predictors of MPD exclusively, but may be indicative of alternative disorders. At the same time these indicators can be invaluable in changing the mindset of persons working closely with children. The objective is not to have persons become overly sensitive to MPD, finding it even where it does not exist. Instead, the intent is to make people aware of these symptoms in order to begin immediate and appropriate treatment. By increasing sensitivity to MPD at this early age, some of the grueling therapeutic work and painful trauma common to MPD in adults might be avoided.

Interviewing

The most practical means of diagnosis is through interviews. If suspicion of MPD is raised there are specialized forms of interviewing that can lead to accurate diagnosis. Initially signs of MPD are subtle and are frequently overlooked. If some indicators suggest the possibility of MPD, the question can take on a more direct character. Interviews of patients in a hypnotic trance or

under the influence of sodium amytal are useful, but must be used with caution (Coons, 1984). An extended interview of several hours increases the opportunity to observe alternate personalities. Likewise, seeing a client for a number of sessions increases the likelihood that MPD indicators will be manifest.

The clinician should be alert to the possibility of MPD with patients who present histories of childhood abuse, sexual trauma, suicidal intent, or "restrictive environment with pronounced religious, authoritarian, or perfectionistic standards" (Boors, 1982b, p. 303). These characteristics could also reflect other diagnoses, but MPD should be considered in every clinical interview.

Additional indicators become useful as the clinician's suspicion of MPD grows stronger. Greaves (1980) summarized eight "signs" useful in diagnosing MPD. Some of these may surface unprompted. Others require more direct inquiry. A patient may use "we" in reference to him- or herself in a collective sense (not just an editorial "we"). Severe headaches, seizures, dreams, visions, and deep sleep are frequently reported. There may be reports of time distortion or time lapses referred to by terms such as "spells" or "blackouts." A history of incidents reported by others for which the patient has no personal recollection is a helpful clue. Similar to this is the discovery of things in the possession of the patient which they can not

account for. As rapport improves patients sometimes will reveal the presence of auditory hallucinations characterized as coming from within the patient's head rather than from external sources. It is helpful to substantiate suspicions of MPD by interviewing others regarding the patient's behaviors. Questions should verify that the patient calls himself by different names or refers to himself in the third person. Hypnosis has been used to elicit different personalities as a final step in confirming the MPD diagnosis.

The use of hypnosis as a diagnostic tool is widely recognized, though controversial. The reluctance of some to acknowledge MPD as legitimate has led to the hypothesis that the multiple personalities are created by hypnosis (Braun, 1984a). Bliss (1983) explains the occurrence of MPD in terms of spontaneous self-hypnosis, although he also sees self-hypnosis as basic to other disorders, including schizophrenia, anorexia nervosa, and sociopathy. Recent studies attempt to clarify this notion by recognizing similarities between hypnosis and multiple personalities, but conclude that "there is no evidence that hypnosis can produce multiple personalities" (Braun, 1984a, p. 195).

The above controversy is more concerned with etiology and theory rather than pragmatic application of hypnosis. Hypnosis as a diagnostic tool can be useful but should be used with caution. Questioning of hypnotized patients needs to be open-ended so as not to suggest the possibility of

having MPD (Coons, 1984). Braun (1984b) states that the usefulness of hypnosis depends upon the competence of the clinician as a hypnotherapist. He reserves hypnosis as a last means of diagnosis for a couple of reasons. Doubt and criticism abound when MPD is offered as a diagnosis, from other professionals, family members, and especially from the patient. By gathering much of the confirming data prior to the use of hypnosis, accusations of creating the disorder can be avoided. There is also the possibility of complicating the disorder by producing "personality fragments" through the use of hypnosis and prematurely exposing the patient to the complexities of their disorder. Finally, he discusses the fragility of persons with MPD. Because of histories of trauma and abuse, it is important to work sensitively through the diagnostic process so the clinician is not perceived as assaultive. Fear is a major issue in the life of a patient with MPD and proceeding too quickly with a mysterious method such as hypnosis could destroy the rapport that is so necessary for treatment. Alternate personalities must be explored slowly and by using a carefully considered plan. The clinician's curiosity and enthusiasm must be subdued. If such cautions are used, Braun (1984b) sees hypnosis as invaluable in confirming the suspected case of MPD, especially in instances where it might otherwise be overlooked.

Conclusions

Final diagnosis and treatment of MPD is best left to specialists. Psychotherapy with patients diagnosed MPD requires well considered treatment plans. Methods that proceed too quickly or without sensitivity to the special characteristics of MPD patients can set back hopes for recovery or even further complicate the disorder. Kluft (1984b) discusses the challenge of working with MPD patients. They place severe demands on therapists and usually require several years of intensive therapy often characterized by suicide attempts, violent outbursts, and resistance towards the establishment of a working relationship with the therapist.

All clinicians need to familiarize themselves with MPD. Physiological testing is unlikely to provide indicators of MPD. An exception is a case in which several testings were done on an individual and results indicated significant differences between tests. A possible explanation might be MPD.

Psychological testing suffers some of the same uncertainty as physiological testing. A distinct MMPI profile representative of MPD does not exist. The Rorschach may eventually prove diagnostically helpful. Further research in this area will be useful.

With the higher incidence of reported child abuse comes the opportunity to identify MPD patients much earlier in the

development of the disorder. Everyone interviewing abuse victims should consider MPD as a possible diagnosis. Helpful checklists exist and are being fine-tuned to aid in gathering more specific information related to MPD. Discovering MPD in childhood may eliminate years of intensive therapy as well as eliminating further trauma were the MPD to go undetected.

Finally, the clinician working with adult patients needs to add MPD to his or her list of disorders being considered through intake interviews and through the course of therapy. Exposure to indicators of MPD such as those listed in this paper should make clinicians more sensitive to MPD if such a patient presented himself for treatment. This is not intended to increase the number of false positive MPD diagnoses. The objective is to assure consideration of MPD if indicators strongly suggest this disorder.

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